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ABSTRACT

This monograph provides principals and school officials with information about coping with adolescent suicide. Section 1, "Introduction," discusses the uncomfortable nature of the topic, cites statistics, and recommends that preventive programs be developed. Section 2, "Causes of Suicide," analyzes stress and depression among youth and suggests that adults become aware of symptoms. "Myths about Suicide," section 3, dispells eight myths, including: (1) Those who openly talk about suicide never commit it; (2) there are suicidal-type people; (3) suicidal people are completely intent on dying; and (4) suicide victims are always mentally ill or psychotic. Section 4, "Warning Signs," discusses clues that are verbal, behavioral, and situational in nature. Prevention techniques involve questions that school officials can ask to gain further insight. "Alienation from the Family," section 5, briefly interprets the effect of family changes upon young people. Section 6, "Prevention," recommends that schools form crisis and study teams, increase staff awareness, initiate parent and health programs, and develop a student peer helping program. Section 7, "What If Tragedy Occurs," presents plans for schools to respond to a suicide, including support activities by the principal. "Afterthoughts," section 8, recommends that principals understand the repercussions of suicide among others and upon themselves. (CJH)

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THE TRAUMA OF

ADOLESCENT SUICIDE

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THE TRAUMA OF

ADOLESCENT SUICIDE

A TIME FOR SPECIAL LEADERSHIP BY PRINCIPALS

Author *Richard A. Dempsey*

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1

Introduction

Adolescent suicide is a topic that has for too long been shrouded in silence. Our western Judeo-Christian ethic has caused us to view suicide as cowardly, shameful, and sinful and for this reason it has become a topic that makes us feel uncomfortable, unsure, and threatened. We are confused about suicide because we have difficulty comprehending the magnitude of despair that would cause a human being to take his or her life.

Because we are so uncomfortable with the topic, it is important that we discuss the subject, forcing ourselves to struggle with the implied problem of values that are involved with suicide. We must find solutions that will keep youth from viewing suicide as the only alternative.

The very morning the author began to write this monograph, the daily newspaper headlined: "Teen Shoots Self in Class" and "Teen Suicide's Body Found." We are all familiar with these kinds of reports in local papers throughout the country.

Sensationalism? Hardly. As you read this monograph, there will be one adolescent suicide attempted each minute somewhere in the country. Today, 18 youths will succeed in their attempt. This year 6,500 young people will commit suicide. Even more astounding is that these numbers may be low, for many suicides go unreported, are masked, or fall under the category of one-car auto accidents. Researchers tend to agree that the "real" numbers of adolescent suicides could be as many as four times the number reported. Not 18 suicides today, but perhaps 72! Not 6,500 suicides this year, but perhaps more than 25,000!

These are frightening statistics; in fact, the subject is frightening. However, it is imperative that we cast aside the taboos associated with suicide, that we reject the conspiracy of silence that has surrounded the word, and that we set ourselves to the task of developing and initiating meaningful programs that will virtually eliminate suicide as an alternative in the minds of youth.

2

Causes of Suicide

Adults view adolescence as the springtime of life where youth exist with no cares in a game-like environment of perpetual play. Too often older people fail to see this period as one of rapid change socially, emotionally, physically, and mentally. It is the most intense phase of development, bringing more changes than any other time of life. It is a time when too many changes are taking place for some youths. One of the biggest changes for adolescence is shedding the relatively comfortable role of a child for that of a responsible adult.

Luleen Anderson, a Quincy, Mass., psychologist who has done research on adolescence and suicide, says there are four developmental tasks that adolescents must master:

- To sever ties with the family and establish them outside the family;
- To assume standards of right and wrong;
- To identify with the sex role for which they were biologically determined; and,
- To select vocational or educational choices.

These tasks are difficult and often create stress.

In adolescents, suicide may be an attempt to resolve unbearable conflict or to punish important people in their lives. Adolescents see suicide as *the* solution; their ability to seek alternative solutions is diminished. A suicide attempt is often a gesture that says: "Notice me, help me because I hurt and I have no answers." Seventy percent of teens who attempt suicide do so between the hours of three in the afternoon and midnight, when they have a greater chance of being stopped or saved.

The causes of suicide are both numerous and complicated. The foremost contributors to adolescent suicides are depression, loss of a parent through death or divorce, loss of a friend, alienation from the family, parental or school expectations for higher achievement, physiological and maturational growth

changes, drug and/or alcohol dependence, peer group pressures and/or ostracism from a group, confusion over developing sex roles, and a lack of understanding of how one fits into a highly competitive and achievement-oriented society.

Any one of these contributors or any combination of them, when coupled with the magical confidence that suicide will transform seemingly unbearable conditions into a Camelot existence, set the stage for tragedy. It might be well to examine two of the most prevalent causes in more depth.

Depression

Depression, the most commonly felt emotion among suicidal persons, is recognized as a prevalent cause of adolescent suicide. Adults too often wrongfully misconstrue adolescent behavior as simply phases in the growth process. Because adolescents lack the insight and experience to gauge and articulate their emotions, these feelings usually remain bottled up in the youth. The longer they remain concealed, the more self-fulfilling they become; the longer young people harbor a feeling of failure, the more certain they become that they are indeed failures.

Adults must be keenly aware of the symptons of depression and actively work to draw them out for realistic examination. Symptoms of depression include a sense of failure, despair, low self-esteem, fatigue, and loss of energy. Abrupt behavior changes, disturbed sleep, dramatic changes in appetite, delinquent behavior, sexual promiscuity, and alcohol and drug abuse are all indicators of depression.

Loss of Parent

The loss of a parent should not be viewed solely as the result of parental death. Loss can also come about from separation, divorce, or extended absence. Adolescents often fail to adjust to a loss of a parent, for whatever reason, and internalize the loss as a rejection by the parent. Many adolescents build this perceived rejection into feelings of guilt that they in some way were responsible for the loss.

The loss of a parent may also remove a valuable role model for the youth and can create altered behavior patterns. We should know, however, that while loss of a parent through death or separation may be a contributing factor in many suicides and suicide attempts, most adolescents do make it through the pe-

riod of trauma, especially when they recognize the situation is irrevocable.

The level of ego strength of the young person, the level of independence already achieved, and the level of support received from significant others are all very important factors in the youth's ability to cope with the situation.

On Education

He always wanted to explain things.
But no one cared.
So he drew.
Sometimes he would draw and it wasn't anything.
He wanted to carve it in stone or write it in the sky.
He would lie out on the grass and look up in the sky.
And it would be only him and the sky and the things inside him that needed saying.
And it was after that he drew the picture.
It was a beautiful picture.
He kept it under his pillow and would let no one see it.
And he would look at it every night and think about it.
And when it was dark, and his eyes were closed, he could still see it.
And it was all of him.
And he loved it.
When he started school he brought it with him.
Not to show anyone but just to have with him like a friend.
It was funny about school.
He sat in a square, brown desk
Like all the other square, brown desks
And he thought it should be red.
And his room was a square, brown room,
Like all the other rooms.
And it was tight and close.

And stiff.
He hated to hold the pencil and chalk,
With his arm stiff and his feet flat on the
floor,
Stiff,
With the teacher watching and watching.
The teacher came and spoke to him.
She told him to wear a tie like all the other
boys.
He said he didn't like them.
And she said it didn't matter!
After that they drew.
And he drew all yellow and it was the way he
felt about morning.
And it was beautiful.
The teacher came and smiled at him.
"What's this?" she said. "Why don't you draw
something like Ken's drawing?
Isn't that beautiful?"
After that his mother bought him a tie.
And he always drew airplanes and rocketships
like everyone else.
And he threw the old picture away.
And when he lay alone looking at the sky,
It was big and blue and all of everything,
But he wasn't anymore.
He was square inside
And brown.
And his hands were stiff.
And he was like everyone else.
And the things inside him that needed saying
didn't need it anymore.
It had stopped pushing,
It was crushed.
Stiff.
Like everything else.

(This was written by a high school senior, two weeks before he committed suicide.)

Reprinted from *School: Pass at Your Own Risk*, by Arthur Daigon and Richard A. Dempsey. Englewood Cliffs, N.J.: Prentice-Hall, 1972.

3

Myths About Suicide

Numerous myths have developed over the years about suicide and the suicidal person. We should explore some of these myths in hopes of setting the record straight and getting an accurate focus on the subject.

MYTH 1. Those who openly talk about suicide never commit it.

There has long been a tragic belief that those who threaten suicide never follow through with the act. Research indicates that as many as 60 percent of those who commit suicide have made statements about their intentions to someone. Verbal threats or even reference to suicide should be construed as a cry for help. Adolescents who openly discuss the alternative of suicide may be asking for intervention. If the cry for help is not heard, or, if heard is not treated seriously, the outcome may be tragic.

MYTH 2. There are suicidal-type people.

Suicide knows no racial, sexual, economic, social, mental, physical, or biological restrictions. The death of a parent by suicide can increase the potential for self-destruction by an adolescent. If that parent is viewed as a positive role model by the youth, the adult's solution can then become the adolescent's solution. Generally speaking, however, death by suicide cannot be "type-cast."

MYTH 3. Suicidal people are completely intent on dying.

Most people who attempt or commit suicide are undecided about whether or not to continue to live. They tend to gamble with death, trusting and hoping that others will help them. Nearly no one commits suicide who has not told others in some fashion how he or she is feeling.

MYTH 4. Once a person becomes suicidal, he or she is suicidal forever.

Research tells us that people who consider self-destruction are in that state for only limited periods of time. This does not mean that this state cannot periodically recur when the individual's perceptions of life become clouded. But if the person receives help when it is needed, there is good reason to believe that suicide as a solution can be removed from the person's alternatives.

MYTH 5. Improvement after a suicidal crisis or attempt means the risk is over.

The turmoil of an attempted suicide can be devastating to an individual, usually creating emotional exhaustion. Research indicates that most suicides occur within about three months after the signs of recovery from an attempted suicide have been observed. It is at this point that the individual usually has sufficient energy to put suicidal thoughts back into action.

MYTH 6. Suicide victims are always mentally ill or psychotic.

Studies of hundreds of genuine suicide notes indicate that suicidal people are extremely unhappy and not necessarily mentally ill. They are suffering from a complex set of forces that manifests itself in seemingly hopeless dependency—a feeling that joy and optimism are not obtainable and that life is not worth the continued hassle.

MYTH 7. Suicide happens without warning.

In most cases, many clues are given that might alert friends and family to the possibility of an impulsive act. It is extremely important that we are attuned to these clues. One of the most obvious indicators of potential basis for suicidal behavior is a rapid change or drastic alteration in one's moods, ambition, interests, involvements, and, in general, a change in lifestyle.

MYTH 8. Inquiring about suicide plans will increase the likelihood of a suicide.

Asking about suicidal thoughts in depressed persons does not increase the risk of suicide. It is important to determine the person's intent. To discuss these plans openly and honestly can do much to put the problems into focus.

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Warning Signs

Against the background of the myths and potential causes for adolescent suicide are certain warning signs which the perceptive observer should know. Some of these clues may be very observable in one potential suicidal person and less obvious in another. Regardless, it is important to be aware that the warning signs for suicide generally fall into three categories: verbal clues, behavioral clues, and situational clues.

Verbal Clues

What appear to be empty verbal comments can provide clues to some deeper thinking on the part of the potentially suicidal person. Comments such as "Life is always such a downer," "I wonder if there really is life after death," or "How do you leave your body to science?" can be clues that a person is really asking for help. More direct statements such as "I wish I were dead" and "You will all be sorry when I'm gone" may reflect the accurate feelings of the speaker.

Neither direct nor indirect statements such as these should go unacknowledged by those associated with the young person, for they may very well signal suicide intent. Awareness of the problem and listening to youth—especially statements related to loneliness, hopelessness, helplessness, and death—can often be the greatest preventive measure a person can take.

Behavioral Clues

Certain behavioral signs that adults should be aware of can signal suicide contemplation. These may include giving away valued possessions such as record or cassette collections, a stereo, or a stuffed animal collection—items that belong solely to the adolescent. The primary reason for this behavior is merely to get one's affairs in order.

Other signs are abrupt changes in mood such as extreme melancholy or despondence, often accompanied by a desire to

seek isolation and withdrawal. Still other signs include inordinate irritability, lack of ability to concentrate or make decisions, showing excessive guilt feelings, and excessive complaining about trivial annoyances.

Situational Clues

Situational clues can range from what adults may see as an inconsequential setback to a major disaster in an adolescent's life. But because the youth's experiential background is usually shallow, these situations can be seen as equally overwhelming. Adults may view a youth's not getting the summer job, not getting into his or her first choice of college, the loss of a friend who moves away, or wrecking the family car as not being catastrophic. The adolescent, on the other hand, often views these differently. To the teenager, these may be seen as equally climactic as a prolonged illness or the loss of a close loved one. For this reason, adults must become attuned to the values of the adolescent and be more aware of what is "really important" to young people.

Prevention Techniques

In the prevention of suicide, teachers, counselors, and administrators must be aware of the reasons for adolescent suicide as well as the clues people who may be contemplating it give. When school personnel become aware of the messages a student is sending, the most important thing they can do is listen calmly. It should be assumed that the implied threat is, in actuality, a real threat. The *casual* comment cannot be put off until after school. It requires the immediate attention of a caring, trusting person who can draw out the student.

Ten critical questions that can create insight into the adolescent's problems are:

How will you do it? Depending on the vagueness or specificity of the plan, the adult should be able to determine a low (no plan) risk factor to a high (use of a quick method, such as a gun or jumping) risk factor.

How much do you want to die? Cognitive therapists ask their patients to place their wish to die on a three-point continuum, with 1. representing little desire to die, 2. a moderate desire, and 3. a great desire.

How much do you want to live? This question forces the student to think about living. The student can at least begin to focus on reasons for living. Again, a three-point scale is used, with 1. representing little desire to live, 2. a moderate desire, and 3. a great desire to live. Cognitive therapists have said that when depression is present, the person's thinking is distorted. These cognitive distortions include the all-or-nothing thoughts about death that prompt suicidal actions.

How often do you have these thoughts? The adult counselor should know whether the student rarely thinks of suicide (low risk) or is constantly thinking about it (high risk).

When you are thinking of suicide, how long do the thoughts stay with you? The adult counselor must know whether the thoughts are under control. Reports that the thoughts are almost out of control (running away) are indications of high risk. Further questioning includes inquiries to determine whether the student can turn off the thoughts, perhaps switching to others less threatening, or can counter with thoughts of reasons for living. Evidence of loss of control of the impulse to commit suicide demands a referral for psychiatric evaluation.

Is there anyone or anything to stop you? This looks for the student's support system or lifeline. When a support system is lacking, it is necessary for the counselor to become the lifeline temporarily until resource persons are identified or the life crisis that is prompting suicidal thoughts gets resolved. Efforts should be made to involve a person who has a significant relationship with the student in monitoring the student's behavior during the time of crisis. If the student is uncooperative and, in the judgment of the counselor, there is a serious threat of a suicide attempt, the counselor is ethically permitted to notify the family. The student should be advised if this step is taken.

Have you ever attempted suicide? Another myth about suicide is that once an attempt has been made, the person will not try again. A history of suicidal thinking, gestures, or attempts represents high risk, and referral to mental health resources is needed. The student with a history of suicidal behavior requires ongoing therapy.

Do you have a plan? If the student has made final plans, such as choosing a specific time, giving personal possessions to friends, writing notes, or saying "good-bye," the risk is very high and referral action is required. Few plans, vague plans, or no plans lower the risk factor.

On a scale from 1 to 10, what is the probability that you will kill yourself? The student's answer to this question will offer a clear signal to take referral action or not. Again, the explanation of the cognitive therapist is that this type of question confronts the all-or-nothing thinking that suicidal persons are experiencing.

What has happened that makes life not worth living? This question begins the investigation of the events that have precipitated so much stress in the student's life, that the feelings of depression, helplessness, and hopelessness are overwhelming. Counselors probe for loss in the student's life and identify the sources of stress. This question is a bridge between the evaluation of the risk of suicide and continuation of counseling. When the decision is to refer the student, there is no need to use this question.

5

Alienation from the Family

It has long been acknowledged that where strong family bonds exist, the incidence of suicide is extremely low. The converse of this is also true. The fabric of the family unit has drastically changed in the past half century. Society has challenged the age-old stereotype of the roles of the father and mother—the father being the provider, the mother the homemaker. The role of the father as the primary wage earner has changed, and in many cases, been surpassed by the mother. Nearly one-half of all households have experienced divorce. The incidence of one adult raising a family in a home without a spouse is observed with growing frequency.

Contributing to alienation from the family is the problem of lack of communication within the family. Society has placed far different demands on adults as well as on youth. Each functions in a subculture of its own and, too often, each fails to communicate needs, ideas, aspirations, and problems. Each group is saying, "I can't understand my parents (or child.)" With this breakdown in communication can come the feeling of alienation.

Suicidal young people feeling this alienation often withdraw in an effort to avoid conflict; they withdraw not only from the family, but often from peers as well. This sense of alienation can be exacerbated by what young people and adults perceive as unrealistic demands by each to achieve and excel.

On the one hand, parents can alienate the child because of their own low self-esteem or neglect; on the other, failure by the youth to understand and articulate these complex issues may result in searching for relief from a life that seems too complicated and painful.

6

Prevention

Crisis Resource Team

A school should have a Crisis Resource Team to help students, staff, and community deal with crisis situations. The team, often composed of a psychologist, nurse, social worker, administrator, counselor, and teacher, is responsible for dealing with the impact of a crisis in the school setting and for being of help to the family or student in crisis.

Booklets that describe the team and its purpose should be distributed to staff and parents. Helpful items are:

- A definition of the Crisis Resource Team
- A Crisis Resource Team Model
- A Crisis Theory
- A model for an initial counseling interview
- A model for those not trained as counselors
- Suggestions for teachers on topics such as divorce, depression, loss, and suicide
- Suggestions on how to deal with a death, and
- A bibliography.

Adolescent Study Team (AST)

An AST is a group often made up of the school social worker, school psychologist, counselors, teachers, administrators, and the school nurse. They meet to discuss students each month. All teachers are given a referral form one week before the meeting date. They are encouraged to refer students when they observe shifts in behavior, depression, withdrawal, aggressive behavior, inability to have friends in the class, excessive shyness, etc. All parties contribute information about the youngster.

A plan is then established. It may be as simple as a weekly meeting with the counselor or favorite teacher or as complex as major intervention and hospitalization with physician recommendation.

The climate of the meeting should be such that titles are unimportant. The focus is on who works best with this youngster: it might be a secretary, custodian, teacher, coach, counselor, nurse, or principal.

The adolescent's name is then brought up each month until normal functioning has been established. In this way, the team tries to ensure they do not lose track of anyone who might show a short gain, but then revert to depression. The principal keeps a confidential record of those students on the monthly list.

Staff Awareness

Teachers new to the school district should receive training about depression and suicide. Once all the staff has an awareness of symptoms of depression and suicide, update information should be given every two to three years to keep the staff current. It should be emphasized that not all staff members will be comfortable dealing with this topic. That should be expected. What must be demanded is that teachers know where to go to get help for a student.

Every effort must be made to convince staff that it is better to overreact to suspected suicidal behavior than to dismiss it because it would be an embarrassment to repeat what might only be a casual remark. Parents have been most grateful even when school personnel have misread the situation. They feel that school personnel care and have extended themselves to prevent a tragedy.

Parent Programs

Parents should be given training on warning signals. Parents can receive regular, updated information through school newsletters, through afternoon or evening coffee seminars on teenage mental health, and through a well-planned lecture series.

Health Programs

Mental health should be part of every health program. Here is another often unexplored avenue to carry on preventive programs that inform students how to help by knowing about symptoms and by knowing where to go for help for their friends. Health programs are usually defined to include mental health; and the topic of suicide, its symptoms, myths, and signals should be part of that program.

Students

School offices could reach more students if more pages were added to the student handbook on depression and suicide. Most students get a handbook annually and most parents of ninth graders read the handbook thoroughly. The handbook should cover the following topics: resources for students, facts and figures on depression and suicide, facts and fables on suicide, warning signs for depression and suicide, and how you can help.

Another way students can help in prevention is to develop a peer helping program. Goals of such a program would be:

1. To train responsible students in the many aspects of the helping relationship so that they can directly attend to the concerns of their peers
2. To encourage communication between students of different backgrounds
3. To provide a link between administration, faculty and parents, and the student body
4. To nurture emotional and interpersonal growth of students within the educational setting
5. To help young people grow into productive, self-sufficient citizens of society.

Goals for peer helpers would be:

- To gain greater self-awareness and confidence
- To develop communication skills including expressing and listening
- To develop sensitivity to personal growth issues and concerns of young people
- To practice decision-making and problem-solving skills
- To learn the importance of personal responsibility
- To recognize and learn how to deal with peer pressure
- To develop their leadership skills
- To develop future career skills
- To develop helping relationships within the educational setting.

7

What If Tragedy Occurs

Programs about suicide prevention, stress, and depression are essential in the school and must be implemented before a tragedy, not as an afterthought. These programs should delineate the warning signs of depression and suicide as a preventive measure and the procedures for handling the situation should it occur. The programs should include intervention sessions so teachers, students, and parents may discuss concerns about stress and suicide.

Students must receive reliable information that dispels the myths, rumors, speculations, and misconceptions about suicide, and school personnel must know what to do to help prevent suicide.

If a student does commit suicide, the program should not be abandoned. Suicide prevention should remain an important issue and students, teachers, and parents should know that help is available to them.

Suicide should not be ignored, nor should it be romanticized or sensationalized. It should be dealt with carefully and compassionately.

The grieving process is essential to the well-being of the students, teachers, and family. Most adolescents can cope with the loss after the initial shock, although some may become depressed for a few weeks or even months. With adequate help, students and teachers will be able to deal with this tragedy.

Schools respond to suicide in different ways. The suggestions offered here are a compilation of several schools' reactions in the aftermath of sudden adolescent death. They are designed to stimulate discussion and help develop a plan for responding to suicide in the school before a tragedy occurs.

- Most adolescent suicides occur on weekends or between the hours of 3:00 p.m. and midnight during the week. If this is the case, the principal should have the time to contact all administrators and faculty members to inform them of the situation and

to request that they arrive at school early to attend a special meeting.

At the meeting, the principal should review the situation with faculty members and administrators and explain the day's agenda.

The school psychologist or an invited psychiatrist or expert should describe how students may react to the news and suggest how teachers might handle the situation.

Time should be allowed for teachers to ask questions and express their feelings.

- The principal should meet with key people (assistant principals, guidance staff, school psychologist) to plan the day's activities and to designate someone to be a spokesperson to communicate with the press. It is a good idea to have only one spokesperson.
- The principal may want to arrange for a psychiatrist or "outside expert" to be at the school to lend support and help to students and teachers. Some people may be wrestling with the notion that something they did or said prompted the student to commit suicide. The psychologist or psychiatrist may be able to dispel this idea or to identify other depressed youth.

In addition, the psychiatrist or expert might speak to parents and to faculty members. They will want to know how to act knowledgeably and confidently.

- For additional support, a crisis center should be established in the guidance office. Students should be encouraged to escort friends to the center and to go there themselves if they need help. Some staff members and students may need to be taken home.

Teachers, guidance counselors, and administrators should concentrate on relating the facts and dispelling the rumors; unglamorizing the event; advising students where they can go to discuss their feelings; encouraging students to be understanding of others' feelings and to help other students to get help if needed; discussing fears, guilt, feelings of responsibility; emphasizing that every adult in the building is willing to help or listen; and encouraging students to express their responses to the death.

- Teachers should be encouraged to relate the facts rather than allow rumors to circulate. Any students' attempts to glamorize suicide should be challenged by teachers and suicide should be

put in proper perspective. The facts of death, the pain suffered by surviving family members and friends, and the decision to die must be discussed.

- Peer counselors can be trained to recognize the warning signs of suicide and know what to do when they identify a suicidal person.

The suicidal person must know that someone cares, understands, and will help him or her. A teenager's preference for peer confidants places friends in an ideal position to help potential suicide victims.

After high-risk students have been identified, the principal should contact their parents and advise them to seek professional help for their youngsters, tell them why they are making this suggestion, and inform them that the school cannot assume the responsibility for the child's safety under these circumstances.

Parents of high-risk students should have the opportunity to speak privately to the school psychologist or expert on adolescent death about why their child is thought to be at risk.

- The principal and any other school representatives should visit the victim's family at home to offer solace and support, return personal belongings, and discuss a memorial service to be held at school.
- A voluntary memorial service should be conducted during the day to acknowledge that the official mourning period is over. A special effort should be made to call attention to the wrongness of suicide. Of course, memorials, such as plaques, may be permitted.
- Some students and teachers may need support for as long as two to three years. Guidance staff members should continue to work with individual students and always try to identify high-risk students.
- School should return to normal as soon as possible.

A final reminder: If a preventive program has been implemented in the school before a tragedy occurs, a steering committee will not need to be organized hurriedly and parents and community leaders will not be tempted to question lack of foresight.

8

Afterthoughts

Sudden adolescent death is very traumatic to all concerned and its impact on the school can be enormous. Generally speaking, principals have no experiential base or formal training upon which to draw in responding to the circumstances. Yet the students, the faculty, and the community all look to principals for guidance and direction. They expect some sort of undefined leadership where a sudden void has been created.

What does one do? What should be done first? How does one provide the leadership and stability in a school community that is acutely distressed?

These are heavy questions that must be addressed by principals. Suffice it to say that there are no single answers to a problem so loaded with emotion. In every instance the situation and conditions are different. The impact on the student body of the death of one youth may be quite different from that of another youth. The external support system needed by one family may differ significantly from the needs of another family.

It is important, therefore, that principals understand the great emotional upheaval that suicide creates and that they take deliberate steps to reduce the painful remorse among the living.

The last thought that we would like to share relates to the psychological impact that teenage suicide can have on principals. During the course of events that surround the incident, principals are expected to display composed, steady leadership. While others may vent their emotions openly, principals are expected to remain calm or even stoic and in so doing bottle up their personal emotions. It is imperative that principals understand this, find ways of taking stock of their emotions, and not harbor them too long. The impact of an adolescent suicide can haunt a person for a long time and for this reason steps may need to be taken to talk out one's feelings with a professional counselor.

Principals should not hesitate to do this. As professional leaders of their schools, as the parent figure of the school family,

their emotional balance during and after the shock of a student suicide is vital to the success of the school's efforts to deal with this consequence-laden tragedy.